MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Dr. Jack Sloane, D.C. P O Box 1404 Decatur, Texas 76234	MDR Tracking No.: M4-03-7002-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Commerce & Industry Insurance Company P O Box 133677 Austin, Texas 78711 Box 19	Date of Injury: Employer's Name: Spigel Properties, Inc. Insurance Carrier's No.: 149-117709

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/20/02	03/20/02	97139-AC	$96.00	$0.00
03/27/02	03/27/02	97139-AC	$96.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

"The Reconsideration EOB included shows payment issued by the IC in the amount of $324 for the two disputed DOS. Only a payment of $66 was received (Copy of check enclosed). We have no record of any further payments for this DOS."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely. Denials listed on the EOBs state, "F-Acupuncture. D-This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice)."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per a conversation with the provider representative on 02/16/05, requestor indicates that the only charges still in dispute are for CPT code 97139-AC, all other charges have been paid.

The provider did not submit product information and redacted EOBs from various insurance carriers indicating what they had paid per rule 133.1(a)(8)(B), 133.307(g)(3)(D) and 413.0011 of the Texas Labor Code).

Therefore, based on the information provided reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

						Total Left Column:	$0.00
						Total Amount Due:	$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

	Michael Bucklin	02/16/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____